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FOR ACTION

COUNTRY PROGRAMME STRATEGY NOTE**

Lesotho

SUMMARY

The Executive Director presents the country programme strategy note for Lesotho for a programme of cooperation for the period 1997 to 2001.

Up to 60 per cent of the population of Lesotho live in absolute poverty, caused by low agricultural productivity and unemployment. Many men migrate to work in the gold mines of South Africa and women are left with heavy responsibilities and few rights. There are significant labour demands on children, who suffer from poor nutrition and lack of access to education. While service delivery in health has achieved some short-term gains, there is a need to decentralize management, improve cross-sectoral coordination and involve communities in monitoring and solving child survival and development efforts.

The proposed programme of cooperation aims to increase broad-based participation through capacity-building and empowerment. Communities will be assisted to become more involved in primary health care, the organization of basic education and primary environment care. The main vehicle for this will be community health and education committees, supported by the district-level administration. The strategy will also include advocacy for and monitoring of the rights of children and women, based on proposed revisions to legislation, improved use of information at community and district levels, and policy and budgetary reform.

* E/ICEF/1996/2.

** An addendum to the present report containing the final country programme recommendation will be submitted to the Executive Board for approval at its third regular session of 1996.

THE SITUATION OF CHILDREN AND WOMEN

1. Since 1973, Lesotho has not produced sufficient food to feed its 2 million inhabitants. Up to 60 per cent of the population live in absolute poverty due to low agricultural productivity and unemployment. Eighty per cent of the population live in rural villages, but urban populations are growing at a rate of up to 10 per cent per year. Fifty-one per cent of households are headed or managed by women, many of whose husbands work in the gold mines of South Africa.

2. Progress towards the mid-decade goals is mixed. The national infant mortality rate (IMR) has declined to 85 per 1,000 live births, but in the highlands it is still 99 per 1,000 live births, while in the lowlands, where 60 per cent of the population live and health services are accessible, it is 76 per 1,000 live births. Between 1992 and 1994, stunting increased from 33 to 42 per cent, moderate malnutrition increased from 15 to 18 per cent and severe malnutrition increased from 2.4 to 5.7 per cent. While full immunization coverage rose to 71 per cent in 1993, there is still a high incidence and poor treatment of acute respiratory infections and diarrhoea. The oral rehydration salts (ORS) usage rate fell from 60 per cent in 1991 to 42 per cent in 1993, and ORS is not available in 52 per cent of the health centres. The ability of health personnel to communicate with parents on preventive measures is poor. The lack of personal hygiene is exacerbated by low access to safe water: 42 per cent in rural areas and 45 per cent in urban areas. Access to safe means of excreta disposal is 65 per cent in rural areas and 63 per cent in urban areas. The current drought has reduced the availability of water by 15 per cent.

3. Seventy per cent of women are literate as compared to 54 per cent of men. The primary school enrolment rate is 68 per cent for boys and 85 per cent for girls, but the completion rate is only 12 per cent for boys and 20 per cent for girls. Boys' enrolment and completion rates are constrained by their traditional full-time work as herdboys. Girls' completion rates are influenced by domestic work and early marriage. The quality of teaching is poor, with 21 per cent of teachers not qualified. School fees are also considered high by rural families.

4. The maternal mortality rate (MMR) is 269 per 100,000 live births largely because 50 per cent of deliveries take place at home and only 20 per cent of them are assisted by trained personnel. Only 54 per cent of pregnant women have access to antenatal care. Thirty-six per cent of women of child-bearing age have goitre. Sexually transmitted diseases and HIV/AIDS are becoming serious problems. Injuries are frequent due to a high rate of violence and alcoholism. Although the Convention on the Elimination of All Forms of Discrimination Against Women has been ratified, women face legal barriers and discriminatory traditional practices. Currently, women cannot inherit land, establish a business or obtain credit without their husbands' consent. Under the law, women are minors.

LESSONS LEARNED FROM PAST COOPERATION

5. To achieve greater impact, there is a need to coordinate the planning and implementation of the projects that UNICEF supports in health, nutrition, water supply, sanitation, household food security, income-generating activities for women, early childhood and youth development, and primary education. Supply assistance also needs to be streamlined to avoid duplication and increase efficiency. A vertical, top-down service delivery strategy has been successful in the short term, but is not sustainable and has led to bureaucratic

inefficiencies. Local institutions need to be strengthened to improve the quality of services and promote management through participatory processes.

6. Statistics are only available for the national level. Lesotho needs to develop a multilevel planning and management information system based on information at the community level. The support of district personnel will be vital in the effective processing, updating and use of information on the situation of all communities.

PROPOSED COUNTRY PROGRAMME STRATEGY

7. The aim of the programme of cooperation is to mobilize broad-based participation in accelerating progress towards sustainable improvements in children's health and well-being. Specific objectives include (a) to reduce IMR from 85 to 50 per 1,000 live births; (b) to reduce MMR from 269 to 65 per 100,000 live births; (c) to reduce severe and moderate malnutrition among children under five years of age from 5.7 and 18 per cent, respectively, to 2 per cent and 9 per cent; (d) to increase the net primary school enrolment rate from 71 to 85 per cent; (e) to increase the primary school completion rate from 30 to 50 per cent; (f) to increase access to latrines from 35 to 65 per cent in urban areas, to rural water supply from 42 to 81 per cent and to urban water supply from 46 to 92 per cent; and (g) to reduce women's workload and time in collecting fuel by 75 per cent. The key strategy will be capacity-building for community empowerment through gender-sensitivity and government-community co-management, with a particular emphasis on legal, informational and policy approaches. Capacity-building will be based on integrated urban and rural assistance packages by all donor agencies, coordinated by the Government and planned in a participatory manner. The constituency plan of action planning process, which has been initiated with UNICEF support, will form the basis for rapidly scaled-up community empowerment in development. The strategy also will include advocacy for the rights of children and women. Service delivery will continue in three interrelated components: basic education and training; primary health care (PHC); and nutrition.

8. The objective in basic education will be to expand coverage and improve quality. In Lesotho, the Ministry of Education and the churches own the primary schools, but community leaders are not involved in the management of education because they lack knowledge and skills. The strategy will be to assist newly established district education officers to provide assistance and training so that communities can establish school management committees and community education committees for community schools supervised by an existing primary school. The quality of teaching will be improved by increased supervision, more detailed learning plans and the use of the mass media to support both teachers and pupils. Teacher training will be improved through the introduction of student-centred, participatory methods involving community resources. Curriculum reforms will focus on literacy, oral expression, numeracy and problem-solving required for survival. Community schools will hold non-formal classes for herd-boys and other school drop-outs. There will also be support for attempts to integrate children with disabilities in the primary school system. Support will be provided for strengthening the education planning and management information system at community, school and district levels.

9. Similar strategies will be followed for early childhood development, which is home- and community-based in Lesotho and receives no assistance from the Government or non-governmental organizations (NGOs). The strategy will be to support women community leaders by training them in nutrition, health, psycho-social development, environmental issues and improved child-care practices.

10. In the health sector, the strategy will be to support national health and nutrition policies which are based on PHC, with an emphasis on Government-community partnership in co-managing decentralized basic health services, the equitable distribution of quality and gender-sensitive health services, and the need for linkages with other sectors. Village and urban development councils will form village health committees where none exist and mobilize technical support and training for community participation in surveys, analysis, project formulation and implementation. Health centres will support greater collaboration among community health workers (CHWs), traditional birth attendants and traditional health practitioners. Village health committees will also monitor the quality of services provided by health centre staff.

11. The quality of preventive, promotive and curative services will be improved through the planning of on-the-job and task-related training of health workers. There will be an emphasis on assessing post-training performance, especially with respect to vaccination coverage; the use of oral rehydration therapy; case management of pneumonia, tuberculosis and diarrhoea; breast-feeding; preventing disability through supplementation for iodine and vitamin A deficiency; women's and adolescents' reproductive health; HIV/AIDS prevention; and family violence mitigation.

12. The nutrition strategy will change from a top-down approach to an integrated, community-based intersectoral approach involving cooperation with relevant agencies at the district level. More appropriate practical training activities will be introduced to enable community leaders and CHWs to monitor the growth of children and to respond correctly to problems of malnutrition.

13. The strategy for primary environmental care will focus on household food security, rural and peri-urban water supply and sanitation, and household energy security. Priority will be given to environmentally-degraded rural and peri-urban communities with high levels of poverty and malnutrition. Through advocacy and training, communities will be encouraged to increase the range of crops grown on home gardens and raise small animals for home consumption. There will be greater emphasis on community involvement in the management and maintenance of rural and peri-urban water supply, especially through the promotion of water harvesting and conservation techniques. In rural and peri-urban sanitation, which aims to double access to safe means of excreta disposal within five years, there will be stronger linkages with PHC, nutrition and education. Household energy security activities will introduce fuel efficient stoves and alternative sources of energy for cooking and heating to significantly reduce the burdens of rural women. Throughout the programme, there will be an emphasis on the convergence of services and networking among NGOs and interested donors.

14. Programme development aims to strengthen the legal framework for the rights of children and women. The Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women have been ratified by the Government. Hence, advocacy will be based on an analysis of national laws and regulations and will recommend changes to those that do not conform with the provision of the Conventions. In addition, training will be provided to rural and urban communities in the rights' approach to the prevention of child abuse and neglect, violence to women and juvenile delinquency.

15. Programme development also will include assistance to policy and programme formulation based on decentralized planning, programming and budgeting. The strategy will be to improve procedures at the district level for information-sharing, planning and intersectoral linkages within the framework of

an integrated programme package. The strategy will be to advocate for the decentralization of resources for development projects to enable the managers at the district level to make decisions on the allocation of resources based on priorities agreed with communities.

16. The provisions of both Conventions will be used as standards against which to monitor programmes implemented by government agencies, church institutions and NGOs. In response to the need to set up a multilevel planning and management information system based on information at the community level, profiles of all 8,500 villages and urban communities in the country will be established and will include information on basic indicators and the projects that are being implemented. This will call for training and technical assistance in the collection, analysis and use of information for problem-solving at district and community levels.

17. The World Bank has allocated $55 million per year to the Lesotho Highlands Water Revenue Development Fund, much of which is earmarked for local development projects. The Government/UNICEF approach to capacity-building for community empowerment will enable communities to benefit from this fund and to manage their own projects.

ESTIMATED PROGRAMME BUDGET

Estimated programme cooperation, 1997-2001 a/
(In thousands of United States dollars)

	General resources	Supplementary funds	Total
Basic education and training	1 500	4 500	6 000
Primary health care and nutrition	1 500	4 500	6 000
Primary environmental care	750	3 250	4 000
Programme development	1 250	2 750	4 000
Total	5 000	15 000	20 000

a/ These are indicative figures only which are subject to change once aggregate financial data are finalized.

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COUNTRY PROGRAMME STRATEGY NOTE**

Malawi

SUMMARY

The Executive Director presents the country programme strategy note for Malawi for a programme of cooperation for the period 1997 to 2001.

Within a new democratic and multi-party Government, the proposed country programme has strategic themes of community empowerment and action, behavioural change and gender equity. The Convention on the Rights of the Child is the major point of reference for a shift of focus from service delivery to empowerment, with a priority on building national partnerships with the Government, non-governmental organizations (NGOs), the private sector and multilateral donors. Survival, development and participation rights provide the framework for the health, water supply and sanitation, family and community care, and education and youth participation programmes. The overall strategy focuses on raising awareness of communities and empowerment, with elements of capacity-building at national and district levels. Youth are considered to be powerful agents of change. Experience with the current AIDS programme will be used as the cutting-edge for promoting community action, particularly in the care and youth programmes. The proposed country programme will support the reduction of child and maternal mortality and malnutrition through the active involvement of governmental and community-based organizations and parents.

* E/ICEF/1996/2.

** An addendum to the present report containing the final country programme recommendation will be submitted to the Executive Board for approval at its third regular session of 1996.

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THE SITUATION OF CHILDREN AND WOMEN

1. The period from 1991-1996 was one of monumental political change, with a move from a one party to a multi-party system. The first democratically elected Government adopted poverty alleviation as its priority.

2. Two-thirds of the population live below the poverty line. Child mortality is among the highest in the region - 135 and 234 per 1,000 live births, respectively, for the infant mortality rate (IMR) and the under-five mortality rate (U5MR). The major causes are malaria and anaemia, followed by pneumonia, measles and diarrhoea. Malawi has achieved the immunization goals with more than 90 per cent coverage, and there have been no confirmed cases of polio since 1992. Forty-eight per cent of all children under five years of age are chronically malnourished. Underlying causes include the lack of household food security, gender influenced and improper child feeding practices, and infections. Micronutrient deficiencies are widespread, and legislation for salt iodation has been adopted. Only 5 per cent of mothers breast-feed exclusively, although breast milk substitutes are virtually unknown.

3. The maternal mortality rate (MMR) is 620 per 100,000 lives births resulting from inadequate information and access to essential services; high-risk reproductive behaviour; illiteracy; poor nutrition; and traditional beliefs and practices, including the low status of women. HIV/AIDS prevalence is one of the highest in the world, with HIV infection at 30 per cent for urban and 12 per cent for rural areas. The social and economic effects and the impact on programming are severe, and it is predicted that there will be 850,000 AIDS orphans by the year 2000. About one half of the rural population have no access to clean water and sanitation. More than 30 per cent of all water points are not functioning at any one time. Knowledge of oral rehydration therapy is 69 per cent.

4. Literacy is 29 per cent for females and 48 per cent for males. Free primary education was introduced in 1994. Malawi is likely to achieve the mid-decade goal for education.

LESSONS LEARNED FROM PAST COOPERATION

5. The national programme of action was well-developed in 1991, but the targets were very high and progress towards the mid-decade goals was initially slow. Little attention was given to gender balance or targeting of assistance to the poor.

6. The success of the expanded programme for immunization (EPI) has not been indicative of a generally well functioning health delivery system, but a special outcome of effective social mobilization. EPI is now more demand-driven, although almost entirely donor financed, and incorporates other preventive services in its delivery system.

7. The area-based approach demonstrated the need for decentralization, a commitment that has yet to be fully implemented. The mid-term review concluded that the success of capacity-building is dependent on (a) the availability of

knowledge and skills; (b) managerial capacity and leadership abilities; (c) the presence of political will; and (d) a resource base for recurrent costs.

PROPOSED COUNTRY PROGRAMME STRATEGY

8. The country programme strategy has been formulated on the basis of its anticipated contribution to the national priority of poverty alleviation, the trends and current status of children and women, the provisions of the Convention on the Rights of the Child, the opportunities of the democratic transition, and the World Summit for Children goals. The objectives are (a) to create an enabling environment that places highest priority on the needs and the protection of children; and (b) to ensure, without gender bias, their health and well-being through the active involvement of governmental and community-based organizations and parents. The programme will assist the Government in reducing IMR from 135 to 100 per 1,000 live births and U5MR from 234 to 175 per 1,000 births. Chronic child malnutrition will be reduced by 25 per cent and MMR by 20 per cent.

9. The overall strategy focuses on raising awareness of communities and empowerment, with elements of capacity-building at national and district levels. A principal thrust will be the mobilization of youth as agents of change.

10. The democratic transition led to an increase of donor assistance mainly for service delivery. Therefore, UNICEF resources will be used for otherwise under-funded strategic investments and innovative pilot initiatives. Service delivery remains important where there is little possibility for community action, or where coverage can be increased through incorporation with EPI. UNICEF will assist to increase the demand for effectiveness and responsiveness of services to community needs.

11. All programmes will have a capacity-building strategy. A focus on the child through increased knowledge of the Convention on the Rights of the Child and a gender-equity approach will be key. Advocacy will create the political and programme context to enable new capacities to function and be accepted.

12. The Convention on the Rights of the Child will serve as the platform for the empowerment and mobilization of communities and individuals for compliance with child rights. Development is dependent on democratic decision-making and the Government recognizes that poverty alleviation is a process through which the poor are empowered. One strategy for empowerment is to centre interventions in the community, using traditional and modern committees and structures, and provide a focus on child rights. This development strategy complements the Malawi Social Action Fund and the United Nations Development Programme strategy through the promotion of district development committees and funds. The other major strategy for empowerment is communication to generate behavioural changes. Communication about the Convention at household and local levels will be used to influence decisions about the use of resources taken by parents and families as they are the primary investors in children. Behavioural change follows the steps of providing relevant information, producing a desire for change, and facilitating the ability to act through the creation of an enabling environment.

13. The social policy, advocacy and communications programme will draw on the new spirit of democratization by supporting the creation of an enabling environment to facilitate behavioural change and influence policies for creating greater awareness of child rights. The social policy component will advocate for the "20/20" concept and will aim to make the best interests of the child a primary consideration of policy makers, opinion leaders and planners. This will include policy review and dialogue and enhancing collaboration with the United Nations system and with the Bretton Woods Institutions, especially in the areas of structural adjustment and debt relief. The planning, monitoring and evaluation component will assist in building capacity for appropriate data collection for improved planning and community involvement. It will emphasize gender disaggregation and use sentinel sites for community surveillance. The child rights' project will strengthen the capacity of the National Commission for Children to act as an ombudsperson and to become the guardian of the Convention on the Rights of the Child. Partnerships will be developed with the National Alliance for Children, Initiatives for the Mobilization of Private Action, the press and activists for the advancement of children's rights.

14. The health programme will contribute to reductions in mortality and malnutrition by sustaining EPI coverage at over 90 per cent; provide trained workers in case management of common childhood diseases in 65 per cent of the health facilities; and increase the portion of birth deliveries in health facilities, the number of referred obstetric emergencies and the involvement of village health committees in health centre management. The healthy child, or EPI Plus, and the sick child projects will contribute to ensuring adequate and sustained preventive (including micronutrient supplementation) and curative services through the incorporation of capacity-building efforts. The safe motherhood project will contribute to meeting the needs of women and neonates during pregnancy and delivery and will be linked to wider reproductive health and family planning services. The health community initiative aims to empower communities, households and individuals to utilize existing health services effectively and appropriately, to demand and obtain new services through both the health and non-health sectors, and to acquire improved health and nutrition knowledge.

15. The water supply and sanitation programme aims to reduce child morbidity and mortality by raising coverage of safe drinking water to 80 per cent and sanitation to 60 per cent in target districts. Hygiene education and sanitation promotion, with mandatory village management of water sources, are essential components of both the shallow-well rehabilitation and the hand-dug well projects in districts suitable for this technology. Gender concerns will be addressed, particularly in sanitation.

16. The objective of education and youth participation is to raise and sustain net primary enrolment to 90 per cent and ensure access of youth to formal and non-formal life skills programmes. Major donors are investing in the formal education system. The primary education project will create and maintain popular demand for enrolment and retention, particularly of girls. The project will mainly involve and empower school committees and parent-teacher associations in the establishment and management of community schools and in training about the value of girls' education. The out-of-school youth project, while strongly linked to the youth reproductive health project, will promote

child and youth policies by increasing dialogue with children, creating a child rights' network and providing opportunities for youth to be heard.

17. The family and community care programme will contribute to ensuring the well-being of an estimated 800,000 AIDS orphans, reducing chronic malnutrition from 48 to 35 per cent and providing increased learning opportunities for preschool children. The early childhood development project will mobilize community resources for the provision of day-care and educational services for young and vulnerable children. Gender analysis of the control of household resources, including cropping, will lead to the consideration of individual food security and identifies the need for child nutrition. This project aims to increase the consumption of oil and micronutrients by young children and pregnant and lactating women in selected small farming communities. Nutrition education and dietary diversification activities will be strengthened. Women's economic empowerment initiatives will focus on peri-urban marginalized areas.

ESTIMATED PROGRAMME BUDGET

Estimated programme cooperation, 1997-2001 a/
(In thousands of United States dollars)

	General resources	Supplementary funds	Total
Social policy, advocacy and communications	2 500	700	3 200
Health	4 500	3 500	8 000
Water supply and sanitation	1 000	5 000	6 000
Education and youth participation	4 250	3 000	7 250
Family and community care	2 500	2 800	5 300
Total	14 750	15 000	29 750

a/ These are indicative figures only which are subject to change once aggregate financial data are finalized.

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COUNTRY PROGRAMME STRATEGY NOTE**

Namibia

SUMMARY

The Executive Director presents the country programme strategy note for Namibia for a programme of cooperation from 1997 to 2001.

The proposed programme will support national and local efforts to ensure that increasing numbers of children enjoy the rights guaranteed by the Namibian Constitution and the Convention on the Rights of the Child. This will be achieved through reaching the goals of the National Programme of Action for Children, which is now integrated into the first National Development Plan. The programme will place increased attention on disparity reduction, with each programme targeting areas where children are at highest risk. The main strategy will be capacity-building and institutional development for service delivery. Empowering communities, through strengthening school-parent committees, water point committees, or community health workers, remains a priority. The programme will continue work in the priority areas of health, nutrition and child rights. Water supply and sanitation activities will focus increasingly on community health and nutrition promotion and will concentrate on areas where diarrhoea is most prevalent. Child protection efforts will continue to address abuse and juvenile justice, and will be expanded to cover child labour and children affected by AIDS. New programmes include youth health and development, particularly for AIDS prevention; a revised programme on strengthening national and local social planning and community participation; and a new programme to strengthen Government capacity for programme communications. The programme also will support monitoring system development, programme evaluations and policy-oriented research on children's rights while expanding mobilization and advocacy with the Government and other partners.

* E/ICEF/1996/2.

** An addendum to the present report containing the final country programme recommendation will be submitted to the Executive Board for approval at its third regular session of 1996.

THE SITUATION OF CHILDREN AND WOMEN

1. Namibia is pursuing a strong rights-based approach to development with a consistent focus on social development. Five years after its break from apartheid rule, Namibia has succeeded in reaching most of the mid-decade goals and is well-placed to meet the World Summit for Children goals.

2. The first accurate measure of the infant mortality rate, 67 per 1,000 live births, came from the 1991 census, which also found an under-five mortality rate of 87 per 1,000 live births and a maternal mortality rate of 225 per 100,000 live births. The main causes of child death remain diarrhoea, malaria and acute respiratory infections (ARI); the low utilization of services is also a factor. Undernutrition is a factor in 40 per cent of deaths, while the incidence of iodine and vitamin A deficiencies is high. HIV prevalence among women at antenatal clinics increased from 5 per cent in 1992 to 8.4 per cent in 1994. It is estimated that by the year 2000, more than 20,000 children will have been orphaned by AIDS.

3. There is near universal access to safe water and sanitation in urban areas, but coverage is 41 per cent for water supply and 12 per cent for sanitation in rural areas. This is the result of a lack of investment and a scarcity of extension staff.

4. The adult literacy rate is 65 per cent (64 per cent for females). New literacy programmes are very popular, with 36,000 people, 77 per cent of them female, enrolled. Eighty per cent of children (82 per cent female/78 per cent male) now attend school for at least four years, up from 59 per cent in 1990. High failure rates are due to changes in the curriculum and the language of instruction. Many teachers have only limited training skills and the average child takes 15 years to graduate. Enrolment among children on commercial farms and in Bushman-speaking communities remains well below the national average.

5. The Caprivi region has significantly greater deprivation than social indicators show for the country as a whole with respect to infant mortality (106 per 1,000 live births), HIV prevalence among women (24 per cent) and incidences of malaria and diarrhoea. Thus, local development capacity-building will be necessary to reduce such disparities.

6. There is a need to broaden awareness of child protection rights and the availability of services. Over one-third of rapes reported in 1993 involved children under 16 years of age, while 93 per cent of juvenile offenders (almost all male) were sentenced without legal representation. Most interventions for children in especially difficult circumstances are very localized.

7. Community development was suppressed in the colonial period. There have been limited advances since independence due to inadequate extension services. Regional councils were created in 1992, but there has been limited development of regional coordination structures.

LESSONS LEARNED FROM PAST COOPERATION

8. The mid-term review showed that efforts to promote individual, household and community empowerment were hindered by a lack of policies, infrastructure and capacity, in the Government and within UNICEF, for effective interpersonal and mass communications. Without these, the improved levels of service delivery

in primary health care (PHC) and basic education proved insufficient to secure full utilization by the public. Training and staff development were most successful when based on needs assessments and the participation of beneficiaries, as in the health and education programmes. Ad hoc capacity-building was less successful. A long-term approach to community development involving regional-level officials is needed to improve the sustainability of expanded service delivery coverage.

9. Immediately after independence, the Government placed highest priority on the development of policies, programmes and capacity-building in the social services. Advocacy was highly effective in mobilizing the Government and non-governmental organizations (NGOs), especially for the protection of children and women, and in maintaining sufficient allocations of Government resources for basic social services. Systems now need to be created for monitoring programme activities and results, while broadening the scope and depth of evaluations.

10. As a result of the mid-term review, UNICEF expanded its capacity in monitoring and evaluation, increased attention to advocacy and communications in the development of the 1997-2001 communications programme, strengthened its support for HIV control among youth, and shifted additional resources to regional levels. The United Nations agencies also are combining efforts to give communication with Namibian families a high priority in the country strategy note.

PROPOSED COUNTRY PROGRAMME STRATEGY

11. The proposed country programme strategy is based on an assessment of conditions of children in Namibia in relation to the provisions of the Convention on the Rights of the Child. The overall purpose of the programme is to support the achievement of the provisions of the Convention, with particular emphasis on the survival, development and protection of increasing numbers of Namibian children. National targets for child survival and development have been established in the National Development Plan 1995-2000 and the national programme of action (NPA). These include reductions in infant and under-five mortality, severe and moderate malnutrition and adult illiteracy rates; achievement of universal access to safe water and sanitation and 80 per cent completion rates in primary education; and the protection of children and the advancement of women. UNICEF support also will fall within the framework of the Government's country strategy note, which focuses United Nations assistance on poverty reduction, regional and local development, HIV/AIDS control and the reduction of gender disparities.

12. The specific objectives of the country programme are (a) to improve home and facility case management so that 60 per cent of children are effectively diagnosed, treated or referred for diarrhoea, ARI and malaria, and to reduce case fatality rates for these diseases from approximately 3 per cent to less than 1 per cent; (b) to increase water supply and sanitation coverage in two areas with low coverage and a high incidence of diarrhoea from 25 to 40 per cent for water supply and from 8 to 50 per cent for sanitation; (c) to increase participation in early child development programmes from 10 to 50 per cent and improve enrolment rates in marginalized communities from 18 to 50 per cent; (d) to encourage behavioural changes, thereby reducing the risk of the transmission of HIV and sexually transmitted diseases, pregnancy and alcohol and drug abuse, among 80 per cent of 10- to 18-year-olds.

13. The country programme strategy will be to support improvements in three household conditions related to the achievement of children's and women's rights: access to basic social services for all children through advocacy and policy research and development; availability of basic social services through capacity- and skill-building for service delivery; and the empowerment of parents and other caregivers with supportive knowledge, attitudes and practices through the strengthening of interpersonal and mass communication capacity. The approach to skills development will be a combination of in-country training, short-term technical assistance and short-term external training. Study tours will emphasize in-country exchanges. The strategy also will address the issues of improving capacity utilization, managerial change and organizational reform.

14. The country programme strategy will be to strengthen the capacity and organizational structures of partner institutions in service delivery, programme communications and public mobilization. Other priorities will include improved planning, monitoring and advocacy for the promotion of children's and women's rights by relevant government and other institutions. This will heighten awareness and improve actions by government and non-governmental agencies to protect women and children, especially in cases of abuse, conflict with the law, child labour and children affected by HIV/AIDS.

15. The health, nutrition and environment programme will support improvements in the accessibility, relevance and use of health services, especially for adolescents. National-level support for capacity-building and institutional development in health will continue, but the strategy will be to increase attention to regions with high morbidity and mortality and to increase emphasis on communications in health and nutrition. A focus on the environment will expand efforts in Caprivi and Omusati regions to improve environmental hygiene and water source development and management.

16. The education and early child development programme will employ distance learning, the recruitment and training of community teachers, the involvement of caregivers in education and the development of affordable boarding strategies.

17. A youth health and development programme will build the capacity of selected ministries and NGOs so that they are able to reach more young people with the life skills and knowledge they need to avoid high-risk behaviours. Approaches will include the use of interactive training packages for teachers and community workers, supported by radio and community theatre. Service delivery will improve the accessibility, relevance and friendliness of health services for adolescents, and especially young women.

18. The objective of the social planning, monitoring and evaluation programme will be the development of regional development programmes for children and women in up to seven regions, based on the availability of funds. The strategy also will continue to focus on the development of sectoral information systems and monitoring of the Convention on the Rights of the Child and the NPA. All programmes will be strengthened through operational research and evaluation, which will also benefit national policy, especially for the development of a social safety net, and staff skills development and institution-building for government departments and NGOs. The information needs of beneficiaries and the country programme evaluation plan will receive high priority.

19. A communications programme will support skills development of staff communication units and extension services to improve their access to households. In this way, parents and caregivers will be empowered with improved

knowledge, attitudes and practices relating to the threats to child survival, protection and development. The emphasis will be on improved child-care practices and greater use of basic services.

20. While all programmes will continue to address children's and women's issues through policy and programme development, advocacy will be the major strategy of the new programme on mobilization for child and women's rights. The institutional capacity of relevant government ministries and NGOs will be enhanced to support child protection efforts.

21. Already strong cooperation with partner United Nations agencies within the context of the forthcoming United Nations country strategy note will be expanded. The PHC Coordination Group will continue with the World Health Organization, the United Nations Population Fund and the United Nations Development Programme (UNDP). UNICEF will support the Food Security and Nutrition Action Plan with the Food and Agriculture Organization of the United Nations and the World Health Organization, while those institutions, plus the United Nations Educational, Scientific and Cultural Organization and UNDP will continue cooperation within the NPA. The programme will work closely within the newly formed Joint United Nations Programme on HIV/AIDS group in planning, implementation and evaluation.

ESTIMATED PROGRAMME BUDGET

Estimated programme cooperation, 1997-2001 a/
(In thousands of United States dollars)

	General resources	Supplementary funds	Total
Health, nutrition and environment	1 500	8 500	10 000
Education and early child development	1 000	4 000	5 000
Youth health and development	750	3 750	4 500
Social planning, monitoring and evaluation	750	3 750	4 500
Communications	500	2 500	3 000
Mobilization for child and women's rights	500	2 500	3 000
Total	5 000	25 000	30 000

a/ These are indicative figures only which are subject to change once aggregate financial data are finalized.

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FOR ACTION

COUNTRY PROGRAMME STRATEGY NOTE**

Sao Tome and Principe

SUMMARY

The Executive Director presents the country programme strategy note for Sao Tome and Principe for a programme of cooperation for the period 1997 to 2001.

Against the background of deteriorating socio-economic conditions, infant and under-five mortality rates have increased since 1981. The immediate causes of child health include malaria, acute respiratory infections, diarrhoeal diseases and anaemia. The country programme strategy will be a central and essential component in the implementation of the national programme of action for children. In this context, the Convention on the Rights of the Child provides a new important framework for UNICEF cooperation. By strengthening community involvement in planning and implementation, the country programme will help to sustain and improve the quality of social service delivery. It will comprise five programmes: primary health care; basic education; water supply and environmental sanitation; social mobilization; and monitoring and evaluation. The small size of the population, the limited geographic area to cover and the successes already achieved in certain areas, such as water supply and sanitation and child immunization, will permit the country programme to address a variety of country goals for children.

* E/ICEF/1996/2.

** An addendum to the present report containing the final country programme recommendation will be submitted to the Executive Board for approval at its third regular session of 1996.

THE SITUATION OF WOMEN AND CHILDREN

1. Sao Tome and Principe is comprised of two islands with a population of 117,504. It is classified as a least developed country. There has been a low level of economic growth, and adjustment policies in place since 1987 have not yet led to an increase in household income. Government budget allocations for health and education have decreased by approximately 50 and 30 per cent, respectively, over the last four years.

2. The Government has set seven ambitious goals for the year 2000 in the national programme of action (NPA) for children. One of the goals is to reduce the infant and under-five mortality rates by one third of their 1993 levels. As it appears that both infant and under-five mortality rates have increased over their 1981 levels, achieving these goals poses a major challenge. Malaria is by far the leading cause of under-five mortality and morbidity, accounting for 41 per cent of under-five deaths, which a malaria control project financed with World Bank assistance should help to reduce. Acute respiratory infections (ARI), diarrhoeal diseases and anaemia are the other main causes of under-five morbidity and mortality. A second goal is to reduce the maternal mortality rate by one half of its 1991 level of 79 per 100,000 live births, which also poses a considerable challenge.

3. The lack of data on the nutritional status of young children makes it difficult to analyse the trends and prospects towards the goal of reducing severe and moderate malnutrition among children under five years old by 30 per cent of the 1985 level of 17 per cent. In comparison, a successful family latrine programme and the involvement of several donors in urban and rural water supply have generated progress towards the achievement of the goals of increasing water supply coverage from 74 to 90 per cent and sanitation coverage from 50 to 90 per cent.

4. With respect to the goal to ensure universal access to basic education and achievement of primary education by at least 70 per cent of primary school-age children, net enrolment is an impressive 81 per cent, thus showing that the goal is achievable. However, the quality of education is severely compromised by a shortage of trained personnel, teachers protesting inadequate salaries through work stoppages and strikes, the lack of classroom space and materials, and large class sizes. While the sixth goal is to reduce the adult illiteracy rate to at least one half of its 1990 level, progress is being made as the literacy rate is 42 per cent for women and 57 per cent for men. The Government's ratification of the Convention on the Rights of the Child is an important step in making progress towards the seventh goal, which is to provide improved protection of children in especially difficult circumstances. The Convention also provides an important framework to promote the reduction of regional disparities among indicators for children.

LESSONS LEARNED FROM PAST COOPERATION

5. Government personnel at national and subnational levels often lacked the knowledge and skills needed for programme planning, monitoring and implementation during the previous country programme. Consequently, the

mid-term review in 1993 concluded that greater emphasis should be placed on capacity-building, especially training activities, to improve service delivery in the most cost-effective ways. As a follow-up to the review, UNICEF has supported more training, a focus that will continue throughout the new country programme.

6. The training and support of community health workers at district and subdistrict levels and the involvement of communities and families in small-scale water supply and sanitation services have highlighted the need to continue to strengthen community involvement in planning and implementation. Where possible, community cost-sharing will help to sustain and improve the quality of social service delivery.

7. It proved difficult to measure the progress made towards the mid-decade and NPA goals due to a lack of reliable data. Consequently, greater attention and increased resources will be channelled by UNICEF and the Government towards monitoring and evaluation activities, including the collection and analysis of data on regional disparities obtained through community surveillances. The proposed country programme will use such findings to make more effective adjustments in activities where progress is lagging.

8. There is a need to improve coordination and information-sharing among development partners to improve the use of limited resources and to create a stronger intersectoral framework for programming. The programme should build upon the positive experiences between the Government and United Nations agencies, particularly through the Joint Consultative Group on Policy. The proposed cooperation, therefore, will make special efforts to improve and strengthen partnerships with non-governmental organizations (NGOs) in terms of both sectoral and intersectoral programmes.

PROPOSED COUNTRY PROGRAMME STRATEGY

9. The Convention on the Rights of the Child and the NPA are the principal references for the proposed UNICEF-supported country programme. The country programme will be a central and essential component in NPA implementation. It will contribute to the country goals for the reduction of infant, under-five and maternal mortality. The country programme will aim to (a) improve the coverage, delivery and quality of social services in the areas of health, basic education, water supply and sanitation; (b) build capacity at all levels in these same areas to strengthen sustainability of services; and (c) strengthen efforts to protect and assist children in especially difficult circumstances.

10. The country programme will employ a mix of strategies. The lead strategies will be capacity-building and service delivery. In addition, important supportive strategies will include both advocacy and community empowerment initiatives. This strategy mix represents an evolution from previous country programmes whose major strategy was service delivery.

11. The coverage of the country programme will be nationwide, although priority will be given to the socio-economically disadvantaged districts of Pague and Caus. The Ministry of Foreign Affairs and Cooperation will be

responsible for overall programme planning and monitoring. Disparity reduction will be a priority, both between urban and rural areas and between girls and boys. Coordination, information-sharing and joint support of programmes with partners, particularly NGOs, will be prominent. UNICEF also will participate actively in the preparation of the country strategy note for United Nations cooperation which will be finalized in 1996.

12. The country programme will be comprised of five interrelated programmes: (a) primary health care (PHC); (b) basic education; (c) water supply and environmental sanitation; (d) advocacy and social mobilization; and (e) monitoring and evaluation. The small size of the population, the limited geographic area to cover and the successes already achieved in certain areas, such water supply and environmental sanitation and child immunization, permit the country programme to address a variety of country goals for children.

13. The PHC programme will pursue strategies aimed at reducing infant, child and maternal morbidity and mortality by diminishing the transmission of vaccine-preventable diseases; requiring that all edible salt be iodized; reducing morbidity and mortality rates due to diarrhoeal diseases by 25 and 50 per cent, respectively; and reducing ARI by 30 per cent. UNICEF support for capacity-building will provide technical assistance, logistic, financial and material support for the implementation of activities in the areas of the expanded programme on immunization, ARI, the control of diarrhoeal diseases, maternal and child health (MCH) and nutrition. The Baby-Friendly Hospital Initiative will be promoted at all MCH health centres which are equipped to assist mothers with birth deliveries and will help them to undertake exclusive breast-feeding and child health care. The programme also will promote growth monitoring at all PHC facilities. Capacity-building efforts, through training for central- and district-level staff and the development of management support systems, will improve all aspects of PHC management. In collaboration with the World Bank and other partners, communities in two districts will be assisted to assume responsibility in planning, implementing and cost-sharing of health programmes.

14. The basic education programme will seek to increase the proportion of children reaching grade five and to increase the proportion of school-aged children attending primary school. To do so, the mix of strategies will include (a) support to teacher training on core curriculum subjects; (b) advocacy for and support to a school health programme, including health education on sexually transmitted diseases; (c) organization of active community participation in all phases of the education process, including the increased involvement of parents in children's education; and (d) extension services to out-of-school disadvantaged children, especially girls and street children.

15. Water supply and environmental sanitation objectives will contribute to the NPA goal of ensuring that 90 per cent of the population have access to safe drinking water and sanitary means of excreta disposal. In order to complement the roles of other donors in urban areas, UNICEF will support rural and peri-urban areas across the country. In collaboration with district-level authorities, the strategy for service delivery will cover spring protection, hand-dug wells, the construction of household latrines, the rehabilitation and construction of small-scale gravity-fed piped water systems, and monitoring of

water quality. Community water and sanitation committees will be formed at all water points. The programme will encourage co-financing and involvement of the community, especially women, with management and maintenance of all facilities. Hygiene education for a healthy environment will be strengthened.

16. People's knowledge and awareness about the Convention on the Rights of the Child is limited. The advocacy and social mobilization programme will promote implementation of the Convention nationwide, and produce and disseminate information, education and communication materials on Facts for Life to support the NPA goals. UNICEF will collaborate closely with national television and radio stations. Government workers, including teachers, health workers and journalists, will be trained to increase their knowledge about child rights. The National Commission on Children will receive support to strengthen monitoring and mobilization for implementation of the NPA.

17. An integrated monitoring and evaluation system will be developed jointly by UNICEF and the Government. A strategy of capacity-building through a stronger, more reliable database for more accurate trend analysis should support improved policies for children and women. Multiple indicator cluster surveys will be used increasingly as a monitoring tool.

ESTIMATED PROGRAMME BUDGET

Estimated programme budget, 1997-2001 a/
(In thousands of United States dollars)

	General resources	Supplementary funds	Total
Health	1 100	590	1 690
Basic education	650	330	980
Water supply and environmental sanitation	850	650	1 500
Advocacy and social mobilization	700	200	900
Monitoring and evaluation	450	-	450
Total	3 750	1 770	5 520

a/ These are indicative figures only which are subject to change once aggregate financial data are finalized.